

# After the Culture Survey: Moving Patient Safety From the Executive Suite to the Bedside



**SOPS PATIENT SAFETY IMPROVEMENT INITIATIVES**

**INITIATIVES TO IMPROVE EVENT REPORTING AND  
NONPUNITIVE RESPONSE TO ERROR**

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**Track:** SOPS Patient Safety Improvement Initiatives  
**Session:** Initiatives to Improve Event Reporting and Nonpunitive Response to Error  
**Date & Time:** April 20, 2010, 11:00 am  
**Track Number:** SOPS T2 – S2

# DoD Tri-Service Culture Survey

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- **The DoD prepared a Patient Safety Culture Survey for employees**
  - All Military Treatment Facilities (MTF) participated
    - ✦ Air Force, Navy, and Army
    - ✦ Inpatient Hospitals and Ambulatory Facilities
- **Originally given in 2006 and repeated in 2008**
  - The DoD provided each MTF with an analysis of the surveys
    - ✦ The analysis of change from 2006 to 2008 was especially important

# Source of this Project

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- **DoD requested interviews with 9 MTFs who made significant progress in a culture of safety from 2006 to 2008**
  - Interview preparation required an in-depth analysis of survey findings related to the Patient Safety Program (PSP)
    - ✦ Analysis highlighted PSP strengths
    - ✦ And revealed PSP weaknesses
- **Project: use survey results to guide PSP enhancements**
  - Survey is research-based
    - ✦ Survey provided tools to collect valid metrics

# Survey Results: Patient Safety Program Strengths

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- Improvements in all areas between 2006-2008
  - Improvements ranged from 3-9%

Patient Safety Culture Area	% Positives		Difference	Change
	2006	2008		
1. Overall Perceptions of Patient Safety	63	69	+6	↑
2. Frequency of Events Reported	60	63	+3	↑
3. Supervisor Expectations & Actions Promoting Pt Safety	73	77	+4	↑
4. Organizational Learning – Continuous Improvement	68	73	+5	↑
5. Teamwork Within Work Area	72	77	+5	↑
6. Communication Openness	58	62	+4	↑
7. Feedback and Communication About Error	65	70	+5	↑
8. Nonpunitive Response to Error	43	47	+4	↑
9. Staffing	41	50	+9	↑
10. Management Support for Patient Safety	72	75	+3	↑
11. Teamwork Across Work Areas	52	55	+3	↑
12. Handoffs and Transitions	41	46	+5	↑
13. Work Area/Unit Patient Safety Grade	75	84	+9	↑
14. Reported Events in Past 12 Months ( <i>Converted from negative to positive</i> )	30	35	+5	↑



Low scores that became focus of project

# Survey Results: PSP Weaknesses

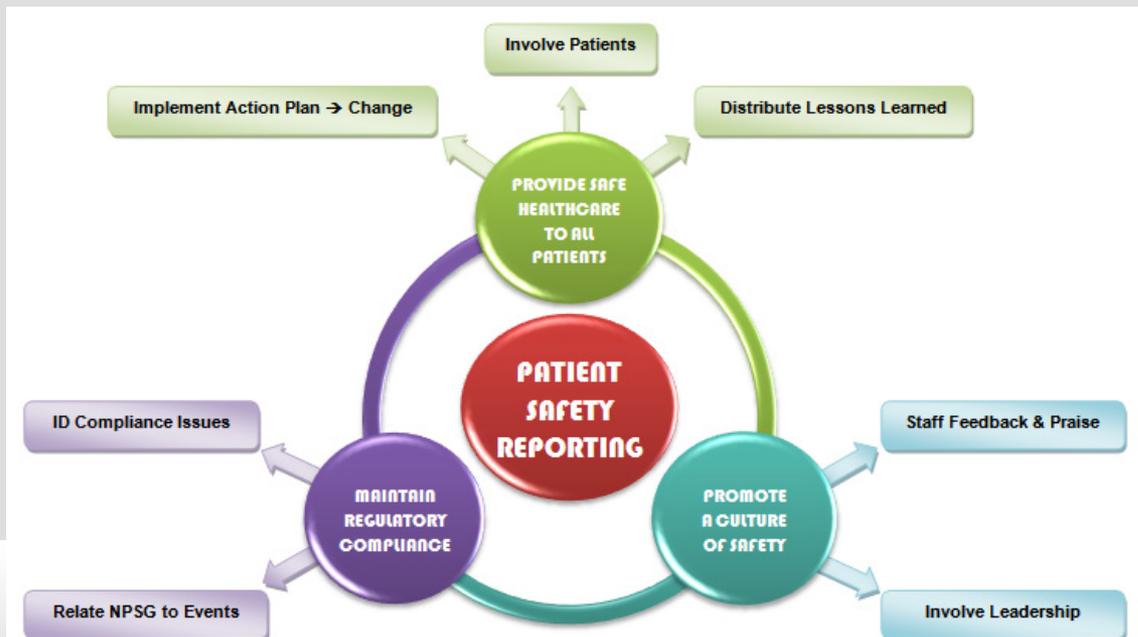
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- **Low survey scores occurred in two areas:**
  - Staff's belief in a non-punitive Patient Safety Program
  - Number of staff who participate in Patient Safety Program by reporting Patient Safety events
- **These metrics fit with our theoretical PSP model**
  - They provided the hypothesis for this project

# PSP Theory in Brief

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- Reporting is at the center of our PSP
  - It quantifies our *Culture of Safety*
    - ✦ As reporting goes up, harm events decline
    - ✦ It measures National Patient Safety Goal compliance
    - ✦ It involves our patients



# Project Hypothesis

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- **Increasing the number of staff who report Patient Safety events will enhance the nonpunitive culture of our hospital**
  - Is the fear of reprisal a hold-over from the healthcare culture before Patient Safety?
  - Unless staff report, how can they know if reprisal occurs?
    - ✦ Only 47% of staff believe error reporting is nonpunitive
    - ✦ Even less – 35% of staff – do any reporting

# The Plan

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- **Increase Patient Safety event reporting**
- **Market a nonpunitive Patient Safety Program**
  - Provide substantive, positive feedback to reporters
  - Leadership assumes active role
  - Share “lessons learned” with all staff
- **Conduct a follow-up mini survey to prove hypothesis**

# Increasing Patient Safety Event Reporting

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- **Increased PS Work Group (PSWG) Reps from 12 - 30 (they represented every clinical area)**
  - Created customized National Patient Safety Goal (NPSG) Compliance Trackers for each clinical area/representative
    - ✦ Non-compliance equals a reportable near miss
- **Utilized patient point-of-care surveys to collect data on NPSG compliance**
  - Non-compliance equals a reportable near miss
- **Monthly Patient Safety Reports reflected near misses and events identified by staff and patients**

# Selling Patient Safety

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- **Answer this question for staff: “What’s in it for me?”**
  - Feedback to reporters includes thanks and actions taken, never blame
  - Participants are recognized by leadership
  - Participation is reflected in evaluations and awards
    - ✦ These are important to military promotion and advancement
  - Elimination of crazy-makers
    - ✦ Many PS events interfere with providing uninterrupted, safe patient care; these are not only risky, but frustrating
  - Real change occurs and safe care becomes easier to give
    - ✦ Takes involved leadership
    - ✦ Requires long term carry-through



# Results of Project: Reporting

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- **Patient Safety average monthly reporting increased 56% while harm events fell 73%**
  - Discreet items observed and audited by PSWG Reps each month increased 430% over the 8 months of the project (Jan thru Aug 2009)
    - ✦ **Less than 3% of the observations/audits in Aug 09, were near misses; National Patient Safety Goal compliance was 97%**
      - Project made the connection between National Patient Safety Goal non-compliance and Patient Safety reporting
        - **The NPSG are not just items to memorize; they impact patient care**
      - **The Joint Commission Survey in Oct 2009 found, “Zero NPSG Findings.”**
    - Patients submitted an average of 585 surveys per month

# Results of Project: Nonpunitive PS

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- Relied on repeat survey to measure
- Staff who claim they report PS events increased from 35% on the 2008 survey to 51% post-project
  - A 16% improvement versus only 5% from 2006 to 2008
- Positive answers to “belief in a nonpunitive response to error” increased from 47% on the 2008 survey to 59% post-project
  - A 12% improvement versus only 4% from 2006 to 2008

# Project Conclusions

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- Reporting Increased
- Nonpunitive Culture Enhanced
- **MOST IMPORTANT RESULT:**
  - Safer patient care as evidenced by decreased patient harm

# Recommendations

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- Every inpatient and ambulatory health care facility will benefit from a Patient Safety Culture Survey that is accompanied by a complete analysis of survey findings . . . *if* . . .

the findings are used to guide and measure change!

# Questions?

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- **Our National Patient Safety Goal Compliance Tracker is available from:**
  - Shelley Drake
  - 99 Medical Group
  - Nellis AFB, NV
  - Email: [shelley.drake.ctr@nellis.af.mil](mailto:shelley.drake.ctr@nellis.af.mil)